Penfield Obstetrics & Gynecology, LLP

- 43 Willow Pond Way, Suite 200, Penfield, N.Y. 14526 Phone (585) 377-5420 Fax (585) 377-3690
- 1520 Route 332, Farmington, N.Y. 14425 Phone (585) 398-2040 Fax (585) 398-3185
- 1734 East Ridge Road, Rochester, N.Y. 14622 Phone (585) 388-7380 Fax (585) 377-3690

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

For a permanent transfer of records, there will be a charge of **$.75 per page** for copying and administrative costs.
*This fee shall not exceed **$30.00**.*

Patient's Name (please print) ____________________

Date of Birth ____________________ **Phone** (________) ____________________

Address ____________________

Street ***City*** ***State*** ***Zip Code***

I authorize Dr. ____________________ **of Penfield OB-GYN, LLP to take the following action:**

☐ **Release Information To**: ***OR*** ☐ **Obtain Information From**:

Dr. ____________________ Phone ____________________ Fax ____________________

Address ____________________

Street ***City*** ***State*** ***Zip Code***

* **Purpose for Release:** ☐ Medical Treatment ☐ Legal Services ☐ Insurance Coverage ☐ Personal ☐ Other ____________________

* **This information may be released by:** ☐ Copy ☐ Fax ☐ Verbal

* **I authorize the release of the following Protected Health Information (PHI) and/or medical records, if such information exists:**

☐ **All Information –** *The request to send **all** medical information will include the release of sensitive medical information such as: HIV/AIDS, Sexually Transmitted Diseases, Psychological/Psychiatric treatment, Drug/Alcohol abuse treatment, etc.* **I understand that this serves as a dual release inclusive of sensitive medical information.**

☐ **All Information with the following exceptions (please specify)** ____________________

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OR **Select desired information to be released:**

☐ Annual Exam Notes ☐ GYN Exam Notes/Assessments ☐ Prenatal Records ☐ Lab tests/Pathology results

☐ Operative Report ☐ Discharge Summary ☐ Other ____________________

*** This authorization covers treatment period(s):**

☐ All episodes of care **OR** ☐ Date Range: ______________________________

*** This authorization expires (date or event)** ____

Note: If no date is entered, this authorization will expire one year from the date it was signed.

*** I understand that:**

- My right to healthcare treatment is not conditioned by this authorization.
- I may cancel (revoke) this authorization at any time by submitting a request to this office. I understand that the cancellation will not apply to information already released in response to this authorization.
- If the recipient is not a healthcare or medical insurance provider covered by the privacy regulations, this information could be re-disclosed.

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☐ I **am not** transferring my care to this physician/facility on a permanent basis.

☐ I **am leaving** Penfield Obstetrics & Gynecology, LLP and transferring my care to this physician/facility permanently.

In order to better serve our patients, your feedback is appreciated

Reason for transferring from Penfield OB-GYN, LLP:

☐ Moving ☐ Insurance ☐ Dissatisfied ☐ Other (please specify): ______________________________________

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Signature of patient or legal patient representative ____

Date _______________________________

If the above signed is a legal patient representative:

Print Name ____ **Phone Number**_____________________________

Relationship to Patient ______________________________________ **Date** ____________________________________

Witness (Optional) ____

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****Penfield Obstetrics & Gynecology, LLP Use Only****

Date information was forwarded ____

Staff member who addressed request to release information ____